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CLINICS.

CLINICAL LECTURES.

Clinical Lectures on Strangulated Hernia. Delivered at St. Bartholomew's Hospital. By Sir JAMES PAGET, Bart., V.P.R.S., Consulting Surgeon to the Hospital. (Continued from page 143.)

LECTURE II.—In the last lecture, I tried to show how the signs of a hernia supposed to be strangulated may be used for guidance in determining whether its reduction must be achieved by operation, or whether any simpler means for reduction may be used. In this lecture, I will speak of the trials at reduction that may be made, or may not be made, before operating.

For a general rule, let me repeat, your first examination of a patient with a hernia supposed to be strangulated should not be with a design to reduce it at once, but rather with a design to make out what shall be done; what are the chances of reduction without operation; what helps shall be used to obtain it, if it be deemed desirable. Of course you may reduce the hernia, if reduction at once be easy; but do not go on trying if it be difficult. If the case be a bad one, you must first decide whether reduction without operation should be even attempted; and, if the attempt is to be made, what and how much it should be. For this decision, here are some general rules, which I find illustrated by my cases.

In very bad cases—as, for instance, when the patient vomits fecal matter and has peritonitis, or is in collapse, with a small rapid pulse, hiccough, or other such

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extreme signs—there should be no attempt at reduction without operation. The risk of the operation is trivial in comparison with that of returning sloughing or ulcerating intestine into the abdominal cavity.

When the coverings of the hernia are so inflamed as to make it probable that sloughing or suppuration has taken place beneath them, reduction should not be attempted without operation; and, even when they are less inflamed, none but very brief and very gentle efforts should be made, for success is improbable, and failure may be mischievous.

The longer the signs of strangulation have existed, the shorter should be the efforts at reduction; and the more acute the signs are or have been, the more gentle should these efforts be. Only here, do not reckon among the acute signs the intensity of pain in recent or greatly enlarged herniæ; for many of the most intensely painful herniæ are reducible with the help of chloroform, though they may need as much force as in any case justifiable.

The longer and the more numerous and forcible the efforts at reduction made, in any case, before it comes under your care, the briefer and gentler should your own efforts be; if, indeed, you do not at once decide that enough has been done, and that there remains no fair chance of reduction without operation.

If you find that you have to do with a hernia which has been habitually irreducible, and in which you have reason to believe that, without any addition to them, the contents of the sac have become strangulated, you had better operate at once. You are not likely to reduce a protrusion which even before strangulation was irreducible.

Let me now suppose that, observing these rules, a first examination of a strangulated hernia leads to the decision that its reduction without operation is to be attempted: I cannot give a single rule of practice that shall always suffice for the next step after such a decision; but, speaking generally, and of a great majority of cases which come under treatment, it is a safe rule of practice that, after a very warm bath and a few hours' rest in bed—say from three to twelve hours, according to the case—a single attempt at reduction, of reasonable force and length, should be made; that, if this should fail, chloroform or ether should be given; that then, in some cases, but not in all, a second attempt should be made; and that, if this should fail, or if it should not be made, the operation should be performed while the patient is still insensible.

The hot bath should be used in all cases that are not very bad, unless in old and feeble persons, whom it might depress too much. Among these, its place may be supplied by very hot fomentations, or by warm poultices over the hernia and the parts near it; and these must be used as the next best things when a hot bath cannot be had. Helped by rest, all these things are certainly very useful, whether by relieving the tendency to irritable muscular action, or by relieving congestion, or by whatever other means. Especially you may see their utility in hospital patients, who are commonly brought in wretched, chilled, and restless, with their herniæ tense and full and very painful, and their abdominal muscles starting into resistance at the least painful pressure. The heat of the bath, and bed, and recumbent rest, may remedy all this; and the hernia may become easily reducible, or may even reduce itself. It is commonly advised to have the bath so hot, and to keep the patient so long in it, that he may be very faint; and during this faintness to attempt the reduction while the patient is still in the bath. I more than doubt the prudence of this advice. It seems to me better to let the patient be simply soothed and relaxed in the bath, then to put him into bed wrapped in warm blankets, lying on his side, on his back, with his knees drawn up, or with his pelvis a little raised, and then, after an hour or two of complete rest, to attempt the reduction. The advantage of this plan is shown in the many cases in which the surgeon gets the credit for reducing a hernia which the house-surgeon has failed to reduce. The house-surgeon tries in the bath, and fails; the surgeon, an hour or two later, succeeds, not, or at least not always, by greater skill, but by reason of the more

favourable condition of the patient after a time of rest and warmth, and of his better position—lying flat, instead of half-sitting as in the bath. This employment of rest and the bath may be helped by opium whenever the hernia is very painful, and the patient too restless to have a chance of natural sleep. A grain of opium may procure the rest necessary for the quietude of the parts, but is less likely to be useful with femoral than with umbilical herniæ, and less likely with these than with inguinal.

In the old, and in others who may have had inactive bowels long before the strangulation, and in whom fecal accumulations or abundant air may be in the large intestine, an enema even of a large quantity of liquid should be used; for the emptying of the large intestine may greatly facilitate the return of the hernia. Purgatives, I believe, had better not be thought of, if there be any marked signs of strangulation. There are no clear indications for determining the cases in which they might possibly be useful; and, if they do no good, they may do grievous harm. I do not doubt that some have gained advantage from purgatives; but in my notes and memory I rather find instances of mischief, and certainly no cases in which there seemed reason to think that the patients were the worse for not taking any sort of purgatives after evidence of strangulation.

After the warm bath and rest—and still speaking of only the majority of cases, for in some there is no time for these things—you may give chloroform or some other anæsthetic, and try to reduce the hernia. How you are to do this, I cannot tell you now; nor what time and force are reasonable to be used. You must imitate what you see done by men of repute, and use the best common sense you can. I can tell you some things that you must not do. You must not go to work as if you were resolvd to reduce the hernia *per fas aut nefas;* you are not to spend an hour or even half an hour about it, or use all your force, or take off your coat and turn up your shirt-sleeves, or kneel on the bed, that you may press with the more weight; you are not to let half a dozen persons try their hands in turn. You are not to do these or the like things, all of which I have known as the sources of dire calamities. You are to be gentle and self-restraining, mindful of the delicacy of some of the structures you are handling, and that you may do them much more harm than would come of the operation which you are trying to avert. These cautions are the more necessary because, when the patient is under chloroform, you have nothing but your own sense and senses to tell you how far you may go without doing harm. The great value of chloroform and ether is that, by abolishing sensation, they put an end to the muscular resistance to reduction which, whether he will or no, the patient makes when hurt by the pressure of his hernia. Hence they are useful in herniæ, in most of which the difficulty of reduction is chiefly due to muscular resistance; in the recent, or in the recently much enlarged; in the inguinal more than in the femoral, and in these more than in the umbilical; in the painful more than in the painless. Chloroform and ether are by so much the most potent helps to the reduction of herniæ, that it may seem as if it would be right to use one of them without waiting for the influence of a warm bath, or recumbency, or any similar means. Sometimes it is right thus to do, especially in herniæ that have only very recently come down and are intensely painful. But more commonly, if there would be danger in waiting for three or four hours, it is because strangulation is so far advanced that the operation ought to be done at once, without any previous attempts at reduction. If there be no such extreme urgency for immediate reduction, there can be nothing but advantage in the use of the bath and the three or four hours' rest in bed; for they may make the hernia reducible, or, even if they fail of this, they may cause changes in it which are beneficial for both the performance of the operation and for the probabilities of recovery after it.

I have been speaking lately of the plans for average or medium cases; and before, of the cases in which no attempt at reduction without operation should be made.

You may ask, Are there any cases in which it is justifiable to wait longer after the warm bath, and rest, and chloroform, and a fair attempt at reduction, have been tried and have failed? I will not venture to say that such a case for waiting cannot happen; but I am clear that your rule, with barely an exception, must be that, when you are satisfied that a hernia is strangulated, and you have failed to reduce it with such helps as I have indicated, you should operate. While the patient is still under chloroform, the operation should be done; and you should prepare for it before giving chloroform. Of course, if you are satisfied that the hernia, though irreducible, is not strangulated, you may wait; but in this case you must watch almost impatiently, for an intestine or omentum that cannot be reduced is very likely soon to become strangulated, and so is one that is inflamed or blocked up in a hernial sac. Still, if no signs of strangulation, especially if no vomiting, should supervene, you may wait from day to day; but if the signs do occur, especially if there arise vomiting, or increase of pain, or increasing rapidity of pulse and breathing, then you must operate at once, and you had better not try again at reduction. The trial is much more likely to do harm than to do good: you had better operate at once. Nothing does more harm to a strangulated or nearly strangulated hernia than the force of an unsuccessful attempt at reduction.

While you are waiting, you may use, in different cases, ice or warm dressings, enemata, aperients, or opiates. I cannot tell you the indications for each of them. I am glad to have had no sufficient experience of waiting to have weighed the several values of these things; glad because I have no doubt that, for every case in which an operation has been avoided by waiting, there have been two cases in which lives have been lost by waiting too long. But there are at least one or two conditions favourable for all cases in which you desire to wait; namely, rest in bed and very sparing food. Nothing should be allowed to disturb the patient's rest, and no handling of the hernia should be permitted. Part of the value of ice and poultices and other like applications is this, that they all keep hands off.

Of other supposed helps I will not speak—of tobacco, and curious postures, and shakings with the legs up and the head down, and cupping-glasses, and other like and unlike things. They are ingenious wrong-doings, more dangerous than the operation which they are intended to avert.

In speaking of herniæ as being reducible, I have had in mind only such as can be completely and certainly reduced. But it is not uncommon to meet with cases of strangulated hernia, in which the reduction is doubtful or partial. As I looked through my cases, I found many of these recorded, in which there was delay in sending patients to the hospital, because surgeons believed that part of the hernia was put back, and hoped that the rest would soon go; and some in which, even in the hospital, there was mischievous delay through the same fallacious hope. It is not easy to say what takes place in these partial or doubtful reductions. Some patients will tell you that the whole never did go back, and that what now seemed to be reduced might only be an additional protrusion. Sometimes, I think, air is pushed back from the intestine, or fluid from the sac; sometimes omentum is put back; sometimes, perhaps, part of the intestine; sometimes nothing—the whole notion of reduction being fallacious. The liability to deception is greater than you would imagine. You may feel a thrill of receding fluid, or a gurgling of air, which you may suppose to be what some describe as the characteristic gurgling (as if anything of the kind were infallibly characteristic), or something slipping back; but all may be fallacious. There is one practical rule for all these cases. If the symptoms of strangulation be not relieved by the supposed reduction; if the vomiting continue, or the pain, or the patient's sense of distress, or any other of the distinctive symptoms, then, without delay, you must operate. A partial reduction of a strangulated hernia, if it be not followed by a complete relief of symptoms, is in nothing better than no reduction.

I may add, that most doubtful reductions are not reductions; and of the partial reductions, none are safe except some of those in which intestine is put back and only omentum remains in the sac.

Be prepared also for cases in which reduction is, or seems, complete, and yet the signs of strangulation are not relieved. In these, a hernia may be returned *en masse*, or pushed into another sac, or between the peritoneum and fascia; or the case may be one of hernia complicated with an internal strangulation, or one of many other conditions so hard to discriminate and deal with, that I can give only one general rule for their management—viz., that if you can feel a lump at or near the hernial ring, as if there were something which may be a strangulated hernia, then you must operate.

To end what I should say respecting the propriety of operating, I ought perhaps to speak of the condition of the patient as affecting the risk of the operation by reason of age and general health and various complications. Among my cases, I find not only many of the fattest and feeblest, but examples of complication with phthisis, acute and chronic bronchitis, aortic constriction, phlebitis, gastric ulcer, diseased bladder, intestinal disorders of various kinds, and internal strangulation. Patients such as these were one would not wound for any trivial good; but, with a strangulated hernia, the peril of doing the operation can hardly ever be so great as the peril of leaving it undone. Old age and feebleness, fatness, intemperance, or unsoundness of whatever kind, may add to the risks of this, as of any other operation; but all these risks must be accepted. A patient must not be allowed to die with a strangulated hernia, if by any means whatever the strangulation can be relieved; and you must not be averted from the operation by any consideration of the number of deaths that follow it. The deaths after the operation may be 50 per cent.; but the deaths due to the operation are not more than 2 or 3 per cent., and even these would probably have been deaths from the hernia if the operation had not been performed. The great proportion of deaths is made up of those in whom the strangulation has done mischief which the operation cannot remedy. It is not unfair to maintain that, speaking generally, the deaths after operations for hernia are only to be counted as failures to save life, while the recoveries are to be counted as lives saved from certainly impending death.—*Brit. Med. J.*

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Clinical Lecture on Tracheotomy in Cases of Laryngeal Disease.—By Ebin. Watson, M.D., Prof. Phys. in Anderson Univ., and Surg. to the Royal Infirmary, Glasgow.

Gentlemen: Chronic disease of the larynx is of many kinds and varieties, and of these you have lately had some illustrations in my clinical wards. Most of these cases get better, if properly treated, without operation; but for this end the patient must be perhaps confined to the house, and certainly retained for a long time under medical care. Hence it is likely that a certain proportion of such cases will become worse from various causes, not quite under the control of either doctor or patient. Again, there is a peculiar danger incurred by this class of patients which can never be wholly obviated—namely, the tendency to acute exacerbations of their disease. This tendency, while in a degree common to all chronic diseases, is peculiarly remarkable in the chronic affections of the larynx, and thus the patient may at any time be brought into imminent peril requiring surgical interference.

These remarks have been dictated by two cases which we have just been watching with much interest—the one to an unexpectedly fatal termination, the other to a more favourable issue. I wish now to call your attention to the chief features of these cases, and the more important clinical points connected with the operation performed in both of them.

The first case was that of a man, aged forty-three, recommended to me by a medical gentleman in the country. I saw him in private some time before his admission to the hospital, and prescribed for him; but, as he became worse, he returned to town, by my advice, to have tracheotomy performed. The case was one of long-continued chronic laryngitis

ending in ulceration of the glottis and necrosis of the right border of the thyroid cartilage. There was also some œdema of the aryteno-epiglottidean folds. I showed some of you these lesions by means of the laryngoscope before operating, for they could thus be quite clearly diagnosed. The stethoscope, however, gave very unsatisfactory evidence of the state of parts because of the great noise produced in breathing; but it was evident that the glottis never yielded sufficiently, and that very little air was admitted to the lungs. Yet the percussion was good over the greater part of the chest, and the man's general health was reported to be fair.

I therefore determined to open the trachea as the obstruction to the breathing was at the glottis, and could not be, at this stage of the case, relieved within a considerable period of time. To enable the man to breathe during the period of treatment was thus the primary object of the operation. But it had also another object—viz., to give the parts complete rest. For as in ordinary breathing the glottis is constantly moving, so still more is it agitated in forced or difficult respiration. Hence the continual aggravation of the ulcers on its surface and the frequent excitement of œdema in its neighborhood.

In approaching the operation of tracheotomy you have first to consider the question of giving chloroform. Now, in the case before us the anæsthetic seemed to act very badly. The man fainted and ceased to breathe, and the operation was performed on him while in a state of apparent death, from which he was only rescued by artificial respiration performed through the tubes. The same thing has happened three times in my experience, and it is very alarming; though I am happy to be able to add that all three cases rallied and recovered. It is very strange that two of them occurred to me in this hospital and during the present session, within a few weeks of each other. Other surgeons have met with the same difficulty more or less frequently, and it becomes us very seriously to consider the cause or causes of the occurrence referred to, and whether or not it should prevent us from employing chloroform during tracheotomy.

I remark here, then, that in some, perhaps in many, of these cases the cause of the syncope is neither entirely due to the chloroform nor to the laryngeal disease. And this is proved by the case under discussion; for, when the patient died, a fortnight after the operation, it was discovered that the surfaces of the pericardium were completely adherent. Now you will remember that the man fainted before he became insensible with the chloroform, and that while in the hospital he had another similar faint without chloroform; and, indeed, I believe he died in a third attack, which might not have been fatal had it not happened during the night—for he was found dead in bed. He had not been so well as on the day before: he had been out of bed for the most part of it, and was cheerful and happy. The faints, and finally his death, were caused by the heart disease; and I believe the faint at the time of the operation was but doubtfully connected with the chloroform. Any agitation or excitement might have produced it, or it might have occurred, as the fatal seizure did, without any cause appreciable by us. And so likewise may it be in other cases. I do not mean that adherent pericardium can reasonably be supposed to exist in any considerable number of them; but I do think it not unlikely that causes quite apart from the action of chloroform, or the conditions demanding operative interference, often occasion the difficulty to which I now refer, and that, as most cases recover, these causes are never definitely discovered. I have, indeed, been sometimes tempted to explain this occurrence as caused by the retention of more than the usual quantity of chloroform in the lungs, owing to the partial failure of the expiratory efforts under the anæsthetic influence, combined with the obstruction of the larynx. This is especially likely in cases of so-called œdema glottidis, in which, when the muscles of the tongue are paralyzed, the œdematous folds at its root and at the sides of the epiglottis are allowed to fall down upon and to fill up the glottis. In this

way a more abundant and rapid absorption of the chloroform would be caused, and it might thus affect the heart so as to produce syncope. Of course it may be said that in every administration of chloroform there is some risk of a similar misadventure; but it is undeniably more frequent in cases requiring tracheotomy than in others. Fortunately, however, it is not, after all, very common; for, out of a considerable number of cases, I have only met with it three times; and I think it need never end fatally if you attend to the precautions I am about to mention to you.

In the first place, be on the watch for its occurrence, and be prepared to combat it. Never, if possible, attempt such an operation without at least one reliable surgical assistant being present to help you. In the next place, be not easily dismayed, and do not for a moment think of desisting from opening the windpipe; on the contrary, proceed, as rapidly as may be, with the operation: introduce the tube and make artificial respiration, taking care that in doing so the tube is not jerked out of the trachea. I beg you not to neglect the practice which you saw me pursue—namely, to pull forward and to jerk the tongue frequently during the period of returning animation. Of course this is not done to admit air to the windpipe, for we suppose that the tube is fairly in the trachea; but I believe it acts as a powerful stimulus to the pharyngeal branches of the pneumogastric nerve, which you know is the chief exciter of respiration. Lastly, persevere long in your efforts at restoration, and, as soon as possible, administer a little brandy-and-water. In one of my three cases it was fully a quarter of an hour before the above-mentioned proceedings could be safely desisted from.

The second of the two cases of tracheotomy which you have seen with me this session was likewise sent to me from the country, and was an example of an acute exacerbation of long-continued laryngeal disease. There were no ulcers visible in this case even on careful examination with the laryngoscope, but only very abundant œdema of the aryteno-epiglottidean folds. Some of you will remember that a year ago this patient was treated by me in Ward 26 for the very same state. The means then used were, free incision of the œdematous masses by means of the laryngeal lancet, and the administration of the iodide of potassium, with the application of iodide liniment over the larynx externally. She at that time recovered; but the present attack was more severe, and, taking into consideration the condition of the glottis beneath the œdema, I recommended tracheotomy as a measure indispensably necessary in order to a more thorough treatment of the larynx.

Now, in your surgical text-books there is a good deal written about the choice of the part of the trachea to be opened in such cases—namely, whether it should be above or below the isthmus of the thyroid body. I do not, however, think that this is much attended to, or much deserving of attention, in practice. I believe that the isthmus is often cut through with perfect impunity, and I am sure that it is seldom seen in the performance of the operation. The great rule which I would impress upon you is, after cutting through the skin and superficial fascia (which you ought to do exactly in the median line), to use the edge of the knife as little as possible. Take the back of its point, or even its handle, and thus separate the muscles in front of the trachea, so as to avoid wounding the vessels; and, if, after doing this, you perceive the isthmus, push it up with the blunt end of the scalpel and clear the tracheal rings below it. You may then plunge in a small sharp hook to steady the trachea, and open it the necessary extent to admit the tube. In a few cases you may find the veins very turgid; and they sometimes are torn or cut, and bleed abundantly. It is now pretty well established as a rule in surgery that you ought not to wait for the complete subsidence of this venous hemorrhage before opening the trachea. Yet it is better to do so if you can, and if there is no very urgent call for haste. You will, in such cases, find acupressure needles very useful, for they may be made to include and restrain bleeding from the entire lip of the wound.

The only other point to which I think it necessary at present to refer is the length of time which a patient may require to wear the tube in the trachea. Now this varies greatly—in my own experience, from a few days to several years. Only a few days ago I withdrew a tracheatube from a boy's throat four years after I had introduced it for him. At the time of the operation his case was very similar to the one on which I have just been commenting, being an acute exacerbation of a chronic laryngitis. I saw him with Dr. James Stewart, whose patient he was, and by whom he had been carefully treated for a long time previously. Soon after the operation he became strong and active. He attended school, and latterly, with his father's family, resided out of town. When he was brought to me the other day, I found the tube quite filled with the granulations, and the boy had a very fair voice, which was improved on withdrawing the tube. I had some difficulty in persuading the parents to allow the wound to heal, but I am sure the tube was no longer necessary.[1]

Other examples of retention of the tube in the trachea for periods nearly as long as in the case just mentioned have come within the range of my own observation, and I never knew any bad results from this cause. Notwithstanding, therefore, a contrary experience in a few exceptional cases, I believe you need not fear to retain a properly made silver tube in the windpipe, even for years, if it is required so long.

The patient on whom I last operated will in all probability require to wear the tube for a long time, because of the nature and previous continuance of her disease; in fact, she must wear it until other measures have had time to effect a cure and enable her to breathe freely though the glottis. The progress of the case will be from time to time ascertained by means of the laryngoscope, which is quite invaluable for all purposes of diagnosis in the larynx, and the use of which is quite indispensable to the right treatment of its diseases. But I cannot in this lecture enter upon the various remedies appropriate to such a case as that before us; I may, however, mention that these must be both local and constitutional, having for their object the complete removal of the œdema and the restoration of the indurated valve of the glottis to its natural mobility. The laryngeal lancet and various kinds of inhalations from the spray apparatus should be first employed, and afterwards the topical application of solutions of nitrate of silver, of different strengths, according to the state of the parts. The chief internal remedy on which I rely in such a case is the iodide of potassium; and sometimes I prescribe a short course of the iodide of mercury, taken at the same time with the other drug. By such means I hope that our patient will in due time be restored to perfect health.—*Lancet*, Aug. 30, 1872.

[1] The wound soon closed up, and the boy remains well.

HOSPITAL NOTES AND GLEANINGS.

On the Use of Plaster Splints in Remedying Displacements in Fractures Irreducible by Other Means.—All surgeons know how difficult it is sometimes to remedy certain cases of oblique fracture of the lower third of the leg, in which the upper fragment projects under the surface. Various apparatus have accordingly been devised for the purpose of preventing this displacement. In France, Malgaigne in such cases used to employ his metallic point, which was fixed into the upper fragment so as to exert a certain degree of pressure, and prevent any fresh displacement. The fixing of the metallic point was attended with some inconvenience; besides, it is a special instrument and not easily procurable. We were therefore struck with the advantages afforded by an ingenious contrivance which we saw Dr. Labbé employ with success a short time ago in his wards at the Hôpital la Pitié.

The patient was a woman aged forty. Whilst in a state of intoxication she had been run over by a gig, and was at once conveyed to the hospital. Fracture of the lower third of the leg was found to have occurred, with very marked displacement of the upper fragment, which projected

under the skin and threatened to tear through. A splint was immediately applied by one of the house-surgeons.

As the woman was labouring under delirium tremens, it was found necessary to use the strait-waistcoat, and strong doses of opium were administered. However, in consequence of the restlessness of the patient, the upper fragment of the tibia projected more and more under the skin, so that it became necessary to use some means to prevent its issue through the surface. Accordingly the apparatus was modified, and a cushion placed under the heel, but to no effect, and there was imminent danger of the fragment lacerating the skin. It was at this time that Dr. Labbé first saw the case, and with the view of definitely remedying the displacement and preventing deformity, he applied a plaster splint in the following manner: Reduction was first performed with the greatest care. As soon as this was completely effected the plaster splint was applied so as to cover the sole of the foot, the heel, and the whole of the posterior surface of the leg. The assistants were then requested to continue extension, counter-extension, and perfect apposition of the fragments, until the plaster had become hard. At the end of half an hour the apparatus was sufficiently solid. From that moment all anxiety about a breach of surface ceased, and, notwithstanding the disorderly movements of the patient, which continued two days longer, consolidation took place so perfectly that it was quite impossible to make out the seat of the fracture.—*Lancet*, Aug. 3, 1872.

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Cases under the Care of SIR HENRY THOMPSON *at University College Hospital:—*

Pain after the Use of the Lithotrite.—Persistent pain after a series of crushings may be due either to soreness of the vesical mucous membrane or to the irritating presence of a remaining fragment. Sir Henry Thompson pointed out, in reference to the following case, that it is important in any given instance to ascertain, once for all, which of these conditions exists; inasmuch as a fragment, if there be one, must be removed without delay; while, if the pain arise from soreness of the mucous membrane, every additional introduction of an instrument is calculated to increase the mischief. Inquiry should be made as to the frequency with which the patient micturates, and as to the occurrence of pain after micturition, and its situation. If any doubt remain, a final and careful instrumental examination should be made; and for this purpose it is desirable that the bladder should not contain much urine. In the case in point the patient had undergone five crushings for the removal of a uric acid stone; he complained of persistent pain in the bladder, with pain in the glands at the end of micturition. Having made a general examination of the interior of the bladder with a sound, Sir Henry Thompson introduced a lithotrite, and, having depressed the handle, carefully explored the region behind the prostate with the slightly separated blades turned downwards. These came into contact with no solid substance, and were brough together without any sense of resistance. On the withdrawal of the lithotrite a very small quantity of powdery matter was found between them. The patient was directed to take a mixture containing liquor potassæ and tincture of henbane, each in the proportion of half a drachm to the dose, and to use a hot hip-bath; and, as a specimen of his urine presented a light deposit consisting chiefly of mucus, the house-surgeon was requested to ascertain whether the bladder was completely emptied by the natural effort.

Painful Ulcer following Ligature of Internal Piles.—Another patient had undergone ligature of some internal piles, and had passed the usual period of convalescence. He complained, however, that the passage of every motion gave rise to agonizing pain at the fundament, and to a long-continued heavy pain in the lower lumbar region. On examination there was found at the spot where one of the ligatures had come away a rough ulcerated surface. So painful was it, that pressure on the corresponding surface of the buttock, about an inch and a half from the anus, could scarcely be

borne. An incision was made through the ulcer as for fissure of the anus.

Urethral Fever.—There occur from time to time cases in which the passage of an instrument into the bladder is followed by exceptionally severe constitutional symptoms. One remarkable case of the kind was lately under Sir Henry Thompson's care. The patient was admitted with a urethral stricture which was first overcome with a small instrument which was tied in the bladder. During the succeeding fourteen days, instruments of gradually increasing size were introduced and tied in; the urethra having then recovered its normal dimensions, Sir Henry undertook to teach the patient to pass a catheter for himself prior to his discharge. He gave the first lesson by himself guiding the patient's hand. Rigors, vomiting, and severe febrile symptoms followed this procedure; the urine became tainted with pus, the intelligence clouded, and the patient's look fixed and stolid; he could keep nothing on his stomach but a little milk and soda-water. When we saw him on the fourteenth day after the occurrence of this complication, his symptoms indicated only a very slight improvement. In speaking of this and other less severe cases, Sir Henry first drew attention to the absolute immunity from similar complications which is enjoyed by women. He pointed out that the male urethra is some six inches longer than that of the female, and attributed to that additional extent of surface the greater irritability and liability to a special form of constitutional disturbance which men display in an affection which always presents three stages: cold, dry heat, and moist heat. Frequent examples are afforded of patients who undergo the introduction of an instrument with apparent impunity, but on their way home a chill is felt, which, with the succeeding symptoms, are attributed to a cold. This complication, Sir Henry said, occurs in various degrees of severity, but seldom does it happen to be so severe as to endanger life, as in the case under observation.

Operation for Recto-vesical Fistula.—To another patient the galvanic cautery was applied to a recto-vesical fistula which had followed an operation for stone performed fourteen years ago. The cautery is applied periodically, and each time its use is followed by improvement. Before the last operation, the patient passed water by the natural passage, but a small quantity escaped into the rectum when he walked.

In the Out-patient Department we saw one or two cases of chronic orchitis and painful enlargement of the epididymis, following gonorrhœa; the patients were directed to keep the scrotum enveloped in a piece of lint covered with an ointment of the following composition:—Half a drachm each of strong mercurial ointment and iodide of potassium ointment to two ounces of simple ointment. Sir Henry advised them to further dilute the preparation with lard, if they should suffer inconvenience from its use. Special injunctions were also given that the part should be well suspended by means of a handkerchief attached before and behind to a girdle of some kind.—*Lancet*, Aug. 31, 1872.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Treatment of Fever by Withdrawal of Heat.—By F. Peyre Porcher, M.D., Prof. of Clinical Medicine in the Medical College of the State of South Carolina.

The article on hyperpyrexia treated by withdrawal of heat, published in the No. of this journal for August last, page 128, brief as it is, is, I think, highly important, as it embodies the method and expresses concisely the principles upon which many of us have heretofore treated and will treat several classes of disease, viz., by the mere *physical abstraction of heat.* If this process is not by itself curative, it tends materially to assist in the cure of several diseased conditions which are accompanied by high temperature.

I invite attention to it on account of its intrinsic merits, and because in the section of my paper in the *Transactions of the S. C. Medical Association*, 1871, on Yellow Fever, in the more detailed sketch of the

treatment of the disease in the *Proceedings* of the same association for 1872 just printed, in papers published in the *Charleston Medical Journal* as long ago as March, 1859, and in a communication on "Gastric Remittent Fever," I laid special stress upon the importance of *the reduction of temperature* in their management. It is indifferent whether this is accomplished by the use of purgatives, mercurial or saline, by quinia, or by the application of cold water, severally or conjointly.

The combustion and consequent destructive tissue changes in some fevers have their origin in gastro-intestinal, hepatic, or other inflammations or irritations of mucous membrane, as in gastro-enteric remittent, in typhoid fever, in hepatitis, etc. Even in these, as well as in others in which there are also real organic lesions, the reduction of temperature by the several means used is beneficial. In yellow fever the force of the disease, the poisoning which gives rise to it, is not seated, I believe, in these tissues or organs, but rather *in the blood* itself. Hence in this disease reduction of temperature has a peculiarly important influence for good. Ice cold water, with other agents, if assiduously and efficiently applied, in time, has much to do with keeping down the high temperature, lessening the combustion, contracting capillaries, arresting tissue changes, and preventing all the dangerous symptoms, such as irritability of the stomach, black vomit, engorgement of the kidneys, albuminuria and arrest of the urinary secretion, coma, and convulsions, which are owing to the altered condition of the blood caused by the high temperature attendant upon excessive fever. I had said (in one of the articles referred to) that "the danger arises from the persistence of a fever of too great intensity, accompanied with a high combustion, and which, if unchecked, leads to all the fatal consequences—to coma, to delirium, to decomposition of blood, to black vomit, hemorrhages, etc. Arrest or diminish the fever and you prevent all these results."

So that in the reduction of "hyperpyrexia" we have a special and separate means, worthy the attention of all physicians, for the arrest and cure of certain morbid states. The same applies in explanation of the use of cold water and irrigation in surgical cases. The method and the application of the means recommended are quite old and have been long used; I only take this occasion to encourage a more systematic resort to them for the reasons given.

The channels in which certain forms of treatment run are often suddenly and greatly deepened by occasionally formularizing and enforcing the reasons for which they have been constructed and used. To do this in the present instance would, I think, be attended with great benefit to physicians and to mankind.

I believe that baths, partial or complete, are useful; but that the most practical and efficient mode of reducing temperature, because more easy of application, is by the assiduous use of cloths dipped in ice cold water applied for from fifteen to twenty minutes to the head and to the palms of the hands, discontinued and repeated at appropriate intervals. This, with the other agencies referred to above, will reduce the intensity and keep in subjection almost any form of fever, as I have observed from repeated experiments.

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Rapid Death from Stings of Bees.—By J. O. SANDERS, M.D., of Carrollton, Mississippi.

April 18th I was called to a plantation two miles distant to see a patient stung by bees. Mr. S., an intelligent man, gave the following account. Louis ——, a negro, aged about 45, climbed a tree where bees had swarmed on a limb, for the purpose of hiving them, carrying with him a saw. As soon as the limb commenced falling, the bees arose *en masse* and covered his head and face. He descended immediately, and, as soon as he reached the ground, commenced running as fast as he could; ran around three sides of a yard, some two hundred steps, passed through an open gate and fell to the ground. Mr. S. ran to him with a bottle of spts. camphor, and succeeded in forcing him to take one swallow, the patient protesting at the time against assistance, declaring that he

would certainly die. After two or three irregular and partial respirations he expired. Mr. S. thinks it could not have been more than five minutes from the time he was attacked by the bees before he breathed his last. When I arrived, about an hour and a quarter after the accident, I could, on careful examination, find no signs of life. He was a vigorous, muscular man, and in perfect health, so far as I can learn. Was death due, in this case, to direct nervous shock, or to absorption of virus, or both?

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Apparent Death.—Dr. W. H. LATHROP, Prof. of Diseases of the Brain and Mind in Detroit Medical College (*Detroit Review of Medicine and Pharmacy*), in his paper on "Apparent Death," reports one of the most remarkable and best authenticated cases of trance on record, that of William (afterwards Rev. Dr.) Tennent. While studying theology at Princeton, N. J., he had a fit of catalepsy, being in a very weak state from close application to books, without proper attention to physical exercise. After a short illness, he was regarded as dead, and the day was fixed for the funeral. His physician, however, believed him to be alive, and succeeded in having the funeral postponed from day to day for three days. The brother of Mr. Tennent then insisted that it was folly to suppose that he could be alive, and ordered that at a certain hour the burial service should occur. When the appointed time arrived, and the company were assembled, the doctor stood over his patient and asked for still another hour. At the end of that time the patient suddenly uttered a groan, and soon after gave other signs of life. His recovery was slow, and at first was attended with a loss of memory. He commenced anew the study of Latin with as much difficulty as if he had had no previous acquaintance with the language. After a considerable time his memory suddenly returned. This case is fully authenticated. The witnesses were educated persons, and all the particulars have been carefully described. Such cases, therefore, are *possible*, though extremely rare.

In conclusion, Dr. L. observes: 1st. That trance is extremely rare; 2d. That apparent life in those really dead is much more common; 3d. That in doubtful cases we should wait for the appearance of decomposition before allowing the burial to take place.

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Yearly Statistics of the New York Board of Health.—Dr. CHAS. P. RUSSEL, Chief of Records of Vital Statistics, in his annual report says: The death-rate for the year was 28.6 per 1000 of the population, a higher rate than can be found in any other city of importance throughout the States, with few exceptions. The total number of deaths caused by zymotic diseases during the year amounted to 8364. Smallpox carried off 805 persons. During 1871, 70 persons, 27 men and 43 women, died at an age exceeding 90 years. Of the total number of deaths, 1071 were due to accidents, 112 to burns and scalds, 15 to kerosene explosions (all women or young girls), 187 to drowning, 395 to fractures, 45 to suffocation, 14 to accidental poisoning, 82 to the Westfield disaster, 93 to steam and street railroad cars, 54 to the July riot, of whom 27 were Irish, 15 Americans, 4 Germans, 3 English, 1 Scotch, 1 Australian and 1 Canadian.—There were 65 murders during the year, but only one murderer, a coloured man, was hanged. There were 114 suicides, of whom the greater part were Germans.—*Medical Record*, Aug. 1, 1872.

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Condurango. — The newspapers announce the death from *cancer*, on the 11th of August last, at South Bend, Indiana, of Mrs. Mathews, the mother of Vice-President Colfax, whose cure by condurango was so triumphantly announced some time since. The result of this case is a sufficient commentary on the value of this greatly vaunted remedy, and will put an end, we trust, to the disgraceful commercial speculation in this drug.

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Health Resorts at the South.—The *Boston Medical and Surgical Journal* for July 11 last contains an interesting article on this subject by Dr. WM. W. MORLAND. The author speaks very favourably of Montmorenci, about four miles from Ai-

ken, S. C., which he regards as a most admirable site for a *sanitarium*.

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Mortality in Philadelphia.—The mortality in Philadelphia is reduced to nearly the ordinary average. The number of deaths during the week ending Sept. 21 was 277, of which 13 were from cholera infantum, and 1 from smallpox. The epidemic of the latter may now be considered as having ceased.

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Medical College of the State of South Carolina.—In the announcement of the session of 1872–73, it is stated that the forty-fourth course of lectures in this institution will commence on the 15th of October and terminate on the 15th of March, thus extending the term one month. This is a step in the right direction, though it does not go far enough, and shows that the public sentiment of the profession is having its influence with the medical schools. The present advanced state of our science and the new field opened for cultivation demand not only a lengthening of the courses of instruction, but also greater facilities for clinical instruction, the appointment of teachers on special subjects, and the institution of laboratories affording conveniences for experimental investigations. To assert that our present system of education is entirely sufficient because some few educated by it have arrived at distinction, is as absurd as to maintain that all education is needless, inasmuch as Hugh Miller, a wholly uneducated laborer in a quarry, attained to high scientific eminence.

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Obituary Notices.—Died in this city, on the 19th of August, at the mature age of 77 years, Dr. John Bell. Dr. B. is well known as a voluminous contributor to medical literature. He is the author of a work on "Baths and Mineral Waters," which has gone through several editions; he edited, with additions, "Stokes' Lectures on the Practice of Physic," "Combe's Treatise on the Physical and Moral Management of Infancy," etc. etc., and contributed very many papers to different periodicals and reports to societies. He lectured for several years in the Philadelphia Medical Institute, and occupied for one session the chair of Theory and Practice of Medicine in the Ohio Medical College. For several years his health had been declining, and incapacitated him from active professional duties.

—— August 15, 1872, in the 62d year of his age, Mifflin Wistar, M.D. Dr. W. was a son of the late eminent professor of anatomy in the University of Pennsylvania, and though he received a thorough medical education, and doubtless would have achieved great professional distinction, yet having inherited a competency he never engaged in practice. He was a high-minded, honourable, refined and modest gentleman, who, though not much known in public life, was greatly endeared to a select circle of friends by his generosity, unselfishness, and thoughtful consideration for the welfare of others.

FOREIGN INTELLIGENCE.

Hypodermic Injections of Quinia.—The salts of quinia, and especially the hydrochlorate, says Dr. Otto, are not sufficiently soluble to be commonly employed in subcutaneous injections, and the surgeon can neither be sure of the dose required, nor of the rapidity of their action. He recommends the use of pure quinia dissolved in ether; this solution is much less irritating than either the acid or alcoholic solutions. Quinia dissolves in ether in sufficient quantity to produce a prompt action, and to permit a considerable dose to be injected. The quinia should be dissolved in the ether, which should then be filtered and allowed to evaporate to some extent, so that a more concentrated solution may be obtained. The solution he uses contains, in about half a drachm, five grains of sulphate of quinia. Dr. Otto has never observed any local inflammation caused by the injection of this solution, and he has injected as much as five grains of the quinia at one time without finding any other inconveniences than those which ordinarily accompany large doses of quinia, such as buzzing in the ears. The injection of this quantity

rapidly produces a depression of the temperature of the body amounting to 1° C. Hypodermic injections of quinia are particularly suitable to cases of puerperal fever, and those of purulent infection; but they may also be employed with advantage in cases of intermittent fever.—*Practitioner*, Sept. 1872, from *Le Mouvement Médical*, June, 1872.

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Rapid Control of Epistaxis.—Dr. Marin, of Geneva, considering that in this accident the blood comes usually from one nostril only, and mostly from the anterior third of the latter, has tried to compress the facial artery on the superior maxillary bone, close to the ala nasi. The efflux of blood into the cavities of the nose is thus stemmed, and the epistaxis soon stops. M. Marin says that he has thus relieved many persons in the street, on board steamboats, in railroad carriages, and even at the theatre.—*Lancet*, July 20, 1872.

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Treatment of Snake-bite by the Injection of Ammonia.—Mr. T. H. Webb, resident surgeon of the Creswick Hospital, writes to the *Australian Medical Journal* touching the treatment of snake-bite by the injection of ammonia into the veins, and he makes the following startling remarks on the careless use of the hypodermic syringe: "The enormous ulcers this caustic creates, the way it burrows, destroying the cellular tissue wherever it touches it, is something incredible. Twice in as many years have I had to ligature the brachial, above and below, for sloughing into the artery, and in both cases have the patients nearly lost their arms from gangrene, and their lives from hemorrhage." He gives the case of a man who had been "hypodermically injected with ammonia; as might naturally be expected, wherever the caustic has entered, an ulcer remains. And such ulcers! One could almost pursue a course of muscular anatomy on his feet, legs, and thighs, whilst at the bend of the elbow the deepness and extent of the slough have compelled him to constrict his brachial. He may well say, 'The evils that it hath pleased Heaven to affect me with I could have borne, but the evils *plus* their remedies—impossible.'" "I declare most emphatically," continues Mr. Webb, "that, instead of the venous injection being a little operation, which anyone can on an emergency perform, it is one that none but a surgeon should attempt, and yet I have several times seen hypodermic syringes in the possession of laymen, kept for the purpose, though how they were going to use them Heaven only knows."—*Lancet*, Aug. 24, 1872.

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Tracheotomy.—M. E. Dudon, of the Hôpital St. André, Bordeaux, has just published the account of twelve cases of tracheotomy which he performed, and in six of which cure was effected. From the careful study of his twelve cases M. Dudon draws a moral which has so often been pointed out, especially by French surgeons, but which cannot be too often repeated—namely, the necessity of not waiting too long before opening. M. Dudon is convinced that had he been able to operate sooner, some of the unsuccessful cases would have ended favourably. The less the false membranes have extended to the trachea and bronchi the better respiration is restored; the less asphyxia is marked and the blood altered, the more the strength of the child will be preserved to resist the disease. "Considering," says the author, "trachetomy to be in itself a benign operation, when viewed independently of the morbid causes which may necessitate it; convinced that if regularly performed upon healthy children it would scarcely ever occasion death; persuaded, as I am, that it is advantageous for children affected with croup to be operated on at an early stage of the disease, before the malady and asphyxia have made any great progress; and backed by the results of my twelve cases, I believe I am justified in saying that tracheotomy is an operation which, to produce all the good results which are expected from it, must be practised early—I mean as soon as the larynx is invaded by the false membranes and medical means have failed. It may well be compared with the operation for strangulated hernia, which, when performed at the beginning of strangulation, after taxis under the influence of chloroform has proved

unsuccessful, affords much more favourable results than when ulceration or gangrene of the intestine and the development of peritonitis have been allowed to take place."—*Lancet*, July 20, 1872.

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Thoracentesis in Infantile Pleurisy.—In the course of the discussion still going on at the Paris Academy of Medicine on empyema, Dr. ROGER, physician to the Hôpital des Enfants, had occasion to relate the results of his vast personal experience of empyema in children. Referring especially to the question of thoracentesis, and basing his opinion upon a great number of facts which he related, Dr. Roger thus tersely summed up his conclusions: Operate *always* in cases of *purulent* pleurisy in children; operate *rarely* in cases of abundant serous effusions; *never* operate in cases of slight effusion.—*Lancet*, Aug. 10, 1872, from *Bull. de l'Acad. de Méd.*

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Skin Grafts.—M. OLLIER, of Lyons, considers that the connective tissue, and not the epidermis, is the active agent in the graft, and objects to sowing a number of small epidermic grafts. He cuts them from six to eight centimetres in length, and they succeed very well; but it is inconvenient to procure such large grafts. He freezes the skin before cutting it away, and finds that it still answers well, notwithstanding this assault upon its vitality. This is a veritable autoplasty, and the healed surface has a more persistent vitality than ordinary cicatrices.—*Brit. Med. Journ.*, April 27, 1872.

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M. Ollier's Occlusive Dressing.—In the last two numbers of the *Lyon Médical*, M. PONCET brings forward some new illustrations of the great advantage attending the employment of M. Alphonse Guérin's mode of dressing wounds with cotton, and associated, as recommended by M. Ollier (*Medical Times and Gazette*, May 11, p. 547), with the silicate bandage, so as to constitute what the latter surgeon terms *occlusion inamovible*. The object of these papers is, however, not to set forth the general advantages of this plan, which have now been made pretty widely known, but to show its great utility in warding off those hospital complications which have so often excited terrible effects—pyæmia, erysipelas, and hospital gangrene. During the last *semester* more than 100 of the *bandages ouatés-silicatés* have been applied in M. Ollier's ward (containing 100 patients) to every wounded surface, and not one of these patients has succumbed to pyæmia or been attacked by erysipelas. The bandage in these cases has been kept on for a week or fortnight, and sometimes three or more weeks; all accidents from such retention being guarded against by paying attention to the pulse, temperature and feelings of the patients. The bandage has had to be removed wholly or in part in a few cases, on account of the imperfect way in which it had been applied. In all cases, wherever possible, such removal has not been performed in the ward where the other patients were; the wound being also kept exposed for the shortest possible time; and the quite new, fine cotton taken only from the parcel as wanted. The portion of this brought in immediate contact with the wound has usually been impregnated with carbolic acid or alcohol. In this mode of dressing the minutest details must be observed, and the great object of exclusion of air can only be attained by the superposition of several thick layers of cotton, which must reach very far beyond the surface of the wound. Thus, after an amputation of the leg, it does not suffice to cover the stump with the silicated bandage, but this must also comprise the thigh and the trunk. Without such precautions it becomes a bad mode of dressing, retaining pus which has undergone change from action of the air in contact with the wound. Before the bandage is applied, as many arteries as possible should be secured, and for this purpose the wound should be left exposed for fifteen or twenty minutes.

M. Poncet gives various details concerning the chief classes of wounds which were treated during this period; and he observes that, if these cases were to be taken as conclusive, this procedure might be pronounced as an absolute preservative against these complications. No cases of pyæmia, erysipelas, or hospital

gangrene were observed in cases so protected, although the last two affections prevailed in the ward. However, he wishes for no exaggeration upon the subject, and observes that, while failure will occur wherever the bandage is imperfectly applied, even when its adaptation is perfect we only place the wound in the very best condition for healing by preventing complications from without. Its healing, however, of course depends also upon other circumstances. It is a means especially adapted for hospital practice, and is not required in cases treated in localities where the air is not likely to be contaminated. The cases M. Poncet relates were also treated in winter; but in summer the dressing may have to be renewed every five or six, instead of every fifteen or twenty days.—*Med. Times and Gaz.*, Aug. 3, 1872.

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Protective Power of Vaccination.—The enemies of vaccination may ponder with advantage over the following facts and figures laid before the British Medical Association at its late meeting, by the Rev. SAMUEL HAUGHTON, M.D., D.C.L.:—

"When I come to England, I am astonished to find intelligent persons in numbers who, for some reason, come forward publicly to oppose the process of vaccination. Some of these people express a strong doubt—an honest doubt—whether the mortality from smallpox is really as fearful as the doctors say. To get a proper basis of calculations as to the mortality from smallpox among unvaccinated persons, we must go back to the records of past generations in this and other countries; and we find this astonishing result, that from 60 to 70 in every 100 persons attacked by smallpox must die if not vaccinated. Some people have the idea that this is a bugaboo of the doctors, and that they need not necessarily die if not vaccinated. Of course it is impossible now to get the experience of an immense number of persons who have not been vaccinated, to give them the smallpox, and see how many would die. This experiment could not be easily carried out. Therefore I adopted another method. I took it for granted that the writers and records of the close of the last century were correct. The average which they gave was that 66 per cent. of every class—men, women, and children—must die if they had got the smallpox and were not vaccinated; whereas, of those who were attacked after being well vaccinated, the number of deaths was only 6.6 per cent. This reduction of the mortality from 66 to between 6 and 7 per cent. represents what vaccination has done. The value of vaccination is, therefore, established beyond the possibility of a doubt, and I think that this is a subject on which the medical profession should speak out. Should not Birmingham, with her literary men and newspapers, lead the public on this great question? I wrote to my friend Dr. Hayden, of the Mater Misericordiæ Hospital in Dublin, to send me the total number of smallpox cases treated there, and of the deaths; and I undertook, from these figures, to calculate the number of those who were vaccinated and those who were not. This forms a very simple problem in mathematics, of which I will not trouble you with more than the results attained. From the figures sent me I calculated, though I had never seen a patient, that 120 of the cases treated at the hospital had not been vaccinated. I wrote to tell Dr. Hayden this, and he wrote back to say that the number recorded as known to be unvaccinated was 119. Since I have come to Birmingham, Mr. Woolley has kindly placed at my disposal all the information he possessed, and I hereby beg to tender him my warmest thanks for his courtesy. Although Birmingham has suffered what I cannot but regard as a most contemptible epidemic, the facts are strikingly illustrative of what, to my mind, is the truth of the principle which I am placing before you. Since the 18th November, 1871, there have been 1911 cases of smallpox, of which 262 have died. I leave out the cases remaining under treatment. I calculated from those figures that 230 persons in Birmingham who had been attacked with the disease had never been vaccinated. I found in Mr. Woolley's returns that the certainly non-vaccinated were 209, while doubtful cases numbered 44. Well, it was fair in such

a case to split the difference and call it 22, and, as that suited my theory very well, I adopted it; and when I added them to the 209 it made 231, which was only one above my calculation. It is like the trick of a conjurer, walking into the town, asking the number of smallpox cases and deaths, never having seen the patients, and yet telling the people of the town how many were vaccinated and how many were not. Dr. Trench tells me that 1616 cases were treated in the Liverpool hospitals; the deaths were 375; from that I calculated that the non-vaccinated cases numbered 451. The number actually recorded as non-vaccinated was 432, being 19 less; but I am perfectly certain that to those should be added several of those properly set down in the reports as doubtful. This opens up a problem highly interesting to the profession of medicine. As the mathematician in his closet can direct the astronomer in what part of the heavens and when to look for certain planets, so the progress of science and medicine can tell with certainty when and where certain districts will be attacked with epidemics. The records of the fearful epidemics and the plagues of the middle ages have perished; the poor have perished with no man to regard them. Even the writings of Defoe may be searched in vain for any statistics of the great plague which would satisfy the demands of modern medical science. But, by examining into the records of our own times, we shall be able to read back the history of the epidemics of the past, the number and percentages of the mortality of those who suffered, who lie forgotten in their graves, and whose history no one has recorded."—*Brit. Med. Journ.*, Aug. 17, 1872.

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Feeding by the Rectum.—The feeding of patients by nutritive enemata in cases of stricture of the œsophagus or pylorus, or whenever the upper part of the digestive tube must be relieved of its functions, has hitherto been anything but a satisfactory proceeding. The ordinary fluid food which is generally used for that purpose is either not retained long enough in the rectum, or cannot be digested there for want of a digestive ferment. Even the proposal of Meissner, to use an artificially prepared meat-peptone, has not always been found practicable, and the long time necessary for its preparation makes it quite unsuitable for daily practice. A decided step in advance has recently been made by Dr. W. O. Leube, of Erlangen (*Deutsches Archiv für Klin. Medic.*, vol. x.). Starting from the idea that it would be best to let the digestive changes which must necessarily precede absorption go on in the rectum itself, with its equable temperature, he devised a mixture of food and digestive ferment which, he found, is easily retained in the rectum from twelve to thirty-six hours. The digestive ferment is the fresh pancreas of the ox or pig, which, finely minced, he mixed with scraped meat, rubbing them well together with a little warm water, so that the mass may be easily injected. The most suitable proportion is one part of pancreas to three of meat. Fat may be added, but its quantity ought not to exceed one-sixth of that of the meat. Before this food is injected, the rectum ought to be washed out with water. Dr. Leube mentions that the first enemata sometimes apparently remain undigested, but that this must not prevent their being continued. Generally the feces resulting when this food has been retained sufficiently long have the character of ordinary fecal matter. By a series of experiments, Dr. Leube has proved that by this method of feeding *per rectum* a considerable quantity of nitrogen is taken up into the system. In a dog, which for several days had been deprived of nitrogenous food, and whose system, therefore, was in a state of nitrogen-hunger, an increase in the nitrogen-elimination by the kidneys took place when these nutritive enemata were given; and, on the other hand, in several experiments on a dog, and likewise on a healthy young man whose system was in a state of satiation with regard to nitrogen, the quantity of nitrogen excreted through the kidneys was not materially diminished when most of the nitrogenous food was introduced by the rectum instead of the stomach. A chemical examination of the feces remaining when the food had been

retained long enough showed that almost the entire quantity of nitrogen contained in the food had disappeared. The same was found with regard to fat; and in a dog that was killed on the second day of the experiment, the epithelial cells of the mucous membrane of the colon were found filled with fat globules. Dr. Leube also relates three cases of patients in whom this method of feeding had been used, and has completely answered the expectations which had been formed from his experiments. Of particular interest is the last case, in which, in consequence of tincture of iodine having been accidentally swallowed, no food whatever could be taken by the stomach, and the feeding by the rectum had to be continued for more than four weeks. In all three cases the general condition of the patients was much improved, although the nature of the cases precluded any but temporary benefit, two of the patients suffering from carcinoma.—*Brit. Med. Journ.*, July 6, 1872.

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Dry Gangrene following the use of Carbolic Acid.—M. Poncet, an *interne* of the Lyons Hospitals, records in the *Bulletin de Thérapeutique* (July 30th) a case which he considers rightly to convey a caution against the rash use of carbolic acid by non-professional persons. A girl, aged 13, had her forefinger injured by a splinter of wood, which penetrated under the nail. The end of the finger was dipped in a bottle of solution of carbolic acid, and a compress soaked in the acid was applied. The next day the part had a grayish colour and was insensible, and when M. Ollier first saw her, a week afterwards, mortification had extended as far as the upper third of the second phalanx, and a line of demarcation was being formed. The finger assumed a mummified appearance, and separated on the thirty-fifth day. This occurrence suggested to M. Ollier the possibility of amputating fingers and toes by means of the application of carbolic acid, and experiments were accordingly made by M. Viennois on rabbits and fowls. The results showed that the application of carbolic acid was liable to be followed by toxic symptoms, but that these might be prevented by the application of a ligature. M. Ollier endeavoured to put the plan into execution in a case of disease of the great toe, by plunging it for some minutes in a concentrated solution of carbolic acid; the thickness of the epidermis, however, prevented mortification from being produced. M. Poncet records also the case of a man, aged 28, who, having wounded the end of one of his fingers, applied for ten days charpie impregnated with carbolic acid, and afterwards poultices. When he applied to M. Ollier, two months after the accident, the terminal phalanx was in a state of dry gangrene, and was removed a few days afterwards.—*Brit. Med. Journ.*, Aug. 31, 1872.

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Sudden Obliteration of the Central Artery of the Retina.—In one of the recent numbers of the *Archives de Phys.* Dr. Sichel records a very interesting case of the above lesion. The patient, aged 54, had been suffering for a long time from insufficient action of the auriculo-ventricular valves, when, after a sharp attack, she became completely blind in the right eye. Examination with the ophthalmoscope showed various small hemorrhagic spots scattered over the fundus of the right eye, and a large hemorrhagic patch in the left. The right, which at first did not permit the patient to distinguish light from darkness, improved after a few days, and then again got worse. Examination of the eye at various intervals showed a commencing atrophy of the optic nerve, and then the conversion of the artery into a whitish and opaque cord. Eighteen months after the outset of the disease the patient died, and Dr. Sichel, on examining the eye, observed an obliteration of the central artery of the retina by a clot which entirely filled up the calibre of the bloodvessel, which he believed was embolism due to disease of the mitral valve. —*Lancet*, Sept. 7, 1872.

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Incontinence of Urine in Children.—Mr. Holmes Coote administers in the above affection, with the happiest effects, even after all other treatment has failed, creasote in minim doses made into pills. —*Med. Press*, Aug. 25, 1872.

Worms in Urine and Blood.—It will be remembered that, during his investigations on cholera in India, Dr. T. Lewis discovered the embryo of a round worm in chylous urine, which is figured in his Report on Cholera. Dr. Lewis has since continued this inquiry in Calcutta, and has not only detected these embryos in large numbers in chylous urine in many cases, but has found them in very large numbers in the blood of patients suffering from chyluria. A single drop of blood from the finger has contained as many as nine live worms. And the identity of these blood-worms with those of the urine is, we understand, beyond doubt. Dr. Lewis's observations will be published in the next Report of the Sanitary Officer with the Government of India, and will be looked forward to with great interest.

A specimen of the embryo of the chylous-urine worm has been submitted to Mr. Busk, who considers it to be some kind of Filaria; and it may not be inappropriate to christen the new entozoon "Filaria sanguinis hominis." It is remarkably like some of the common tank-worms; and the mode of entrance into the body (probably with the water), its growth and increase there, and the effects it produces, are matters of the highest interest, which we hope Dr. Lewis may soon clear up.—*Lancet*, Aug. 31, 1872.

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The Bile Pigments.—By the action of sodium amalgam on an alkaline solution of bilirubin, out of contact with air, Maly (*Ann. Chem. Pharm.*, clxi., 368) has obtained a yellow colouring matter of feebly acid character, which he names *hydro-bilirubin*, and believes to be identical with the colouring matter obtained by Scherer from urine, with that obtained from feces by Vanlair and Masius, and also with Jaffe's *uro-bilin*. He assigns to it, in a later paper, the formula $C_{32}H_{40}N_4O_7$ (new notation). This direct conversion of bile pigment into urine pigment is highly interesting.—*Lancet*, Sept. 7, 1872.

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Inflammatory Agents of Pus.—Dr. Chauveau, of Lyons, pursuing his researches on the general physiology of virulent fluids, has just published in *La Revue des Cours Scientifiques* an account of several experiments made with pus. The main result of these experiments (concludes M. Chauveau) has been to show clearly that putrid pus, which induces fatal results when injected into the tissues, becomes almost innocuous when it has been perfectly filtered, thus giving evidence of the corpuscular state of the inflammatory agents of pus.—*Lancet*, Aug. 10, 1872.

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Unhealthy Revaccination.—*L'Imparziale* states, on the authority of the *Gazetta della Spezia*, that recently seventeen persons were admitted into hospital, after revaccination, with large phlegmonous swellings of the arms at the points where the operation had been performed. In one man, a sailor, sloughing took place, and was followed by death. The cases occurred in persons who were all revaccinated on the same day; and none of those operated on on other days were affected. The occurrence is attributed to bad lymph—taken probably from a diseased cow. *L'Imparziale* remarks that further information is required, before any definite conclusion can be arrived at as to the cause of the unfortunate event and the measures which should be taken to prevent its recurrence.—*Brit. Med. Journ.*, July 13, 1872.

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Women Midwives.—We extract from the *Med. Times and Gazette*, June 15th, 1872, the following remarks, which, we have no doubt, are well founded:—

"It is a matter of notoriety that, of late years, among the numerous outcries that have deafened the well-to-do population of these islands, there has been a shrill, if not a loud, one in favour of female midwives. When traced to its originators, however, it has been found to have been raised by a few male fanatics, whose objection to male practitioners is based on the fact that they credit all mankind with the same impurity which colours their own imaginings; and by a somewhat larger number of hopeless spinsters and sterile matrons, who because they are spared the burden of Eve are envious of Adam's punishment, and employ their time in prating about woman's work and

woman's mission—by which they mean the neglect of that part of the business of mankind which, in every nation and age, has been assigned to the woman, and an interference with that part which nature, custom, or the progress and necessities of civilization have apportioned to the man. Our modern prophetesses quite ignore the fact that the instinct of the human race has made a broad division in labour; that to the female part of mankind nature has assigned three very important duties, which certainly in England they do not fulfil in any tolerable fashion. The first is the duty of preparing food for the whole race; the second is that of clothing themselves and their children, if not the men also; the third is that of educating physically, mentally, and morally the young of the race. This is the true woman's work, which is utterly neglected by a large part of the sex, very badly performed by the great majority of the remainder, and only well fulfilled by the small minority that remain in so far as they profit by the assistance and imitate the skill of those males who, in sheer despair, have turned their attention to what ought to be the female part of human employment. We utterly deny that there is any appreciable call for female midwives on the part of the childbearing matrons of England and Wales. We never yet met with a woman who would not prefer being attended by a man if she could afford to pay one; and the reasons are obvious. In the first place, the instinct of the woman teaches her to rely upon the skill, courage, presence of mind, and strength of the male; in the second, she mistrusts the judgment of her sister in time of difficulty and danger; in the third, she knows that men are kinder and more considerate towards women than women are to each other. We do not believe that if all the married pregnant women in the kingdom were polled to-morrow, one in 500 would prefer being attended in her approaching parturition by a female practitioner. We allow, then, that there is an outcry for female midwives, but we deny *in toto* that it has been raised by that section of the sex which is most interested in the matter."

Hydrate of Chloral in the Prevention of Sea-sickness.—Dr. J. C. O. Will states (*Lancet*, July 20, 1872), that "during the spring of 1872 an unusually favourable opportunity for experimenting as to the value of chloral in sea-sickness presented itself, viz., an exodus of stone-cutters which took place from Aberdeen to New York, and of this I gladly availed myself. Being appealed to by a considerable number for 'a cure for sea-sickness,' I ordered in every case hydrate of chloral. Its effects were of the happiest description; for out of upwards of eighteen cases, in one only did the drug fail to fulfil the indications for which it was prescribed. The weather during all the voyage was rough, and sickness among the other passengers was exceeding prevalent. So satisfied were the men who went out first of the efficacy of the medicine they had employed, that they wrote home, directing those who were to follow to supply themselves with similar prescriptions. I may also mention the case of a young lady, a martyr to sea-sickness, who on sailing the other day had no sooner left this harbour than she began to feel sick. She therefore, according to my directions, took a dose of chloral and lay down, the result being that during the whole passage, lasting two days, she was perfectly free from her former enemy. The same result has attended many other cases in which I have given it. The dose I generally employ is thirty grains in slightly sweetened water, directing the patient to take a like quantity if relief does not follow in twenty minutes. I advise a little light, easily digested food to be taken before sailing, and direct the chloral to be taken and the patient to lie down on the first symptoms of sickness presenting themselves."

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Death under the Administration of Chloroform.—We regret to record another death from the administration of chloroform, which took place at the Great Northern Hospital on Wednesday. The patient was a man fifty-three years of age, on whom Mr. Carr Jackson was about to perform the operation of lithotomy. The vapour was administered by Mr. George Eestes, the chloroformist of the

hospital, who has had extensive experience in anæsthetics. Mr. Osman Vincent, Mr. Vernon, and Mr. Bloxam, all experienced chloroformists, were present; but the efforts of all were unavailing in restoring the unfortunate man to consciousness.—*Brit. Med. Journ.*, Aug. 24, 1872.

Dr. GLASCOTT exhibited to the Manchester Medical Society the heart of a man who had recently died at the Manchester Royal Eye Hospital whilst chloroform was being administered to him previous to an intended cataract operation.—*Ibid.*

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Death from Bichloride of Methylene.—The death of a patient while under the influence of bichloride of methylene occurred last week at the Bath United Hospital. A man aged 51, who had had his arm broken and his shoulder dislocated on April 29th, and who had for some time been a patient at the hospital, was about to be operated on by Mr. Gore for the reduction of the dislocation. The bichloride of methylene was given, and the patient became insensible in two or three minutes, but his face then became livid and his breathing suspended. The pulse was at the same time observed to fail The tongue was drawn forward, ammonia was given, and the galvanic battery was used for three-quarters of an hour, but without effect. The heart was found to be large and flabby, but there was no other sign of disease in the organ. In his evidence at the inquest Mr. Gore said that, according to the records of the hospital, bichloride of methylene had been used there two hundred and fifty times in the last two years.—*Brit. Med. Journ.*, Aug. 31, 1872.

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Five Cases of Hemianæsthesia.—At a recent meeting of the Biological Society of Paris, Dr. CHARCOT, of La Salpétrière, gave the details of five cases of hemianæsthesia with unilateral trembling which he had observed. The patients had been all of advanced age, and had had a more or less sudden attack of apoplexy, after which hemiplegia, hemianæsthesia, and hemichorea had supervened. In three cases a post-mortem had been made, and Dr. Charcot had stated the existence of a sclerous or hemorrhagic lesion of the optic layer, radiating more or less towards the cerebral peduncles and the corpora striata. Dr. Charcot said he did not pretend to furnish the definitive explanation of hemianæsthetic phenomena, but thought he might rationally conclude, from his cases, that there existed in the nervous centres a special situation, the lesions of which produced hemianæsthesia of general sensibility.—*Lancet*, August 24, 1872.

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Character and Treatment of Malignant Scrofulous Angina.—Dr. CONSTANTIN PAUL, in a long article published on the above subject in *l'Union Médicale* (number for July 23d), reviews the whole question of malignant scrofulous angina, as elucidated by the details of twenty cases which he has been able to observe. The chief points of the paper may be summed up thus: There *does* exist a malignant ulcerated angina of a scrofulous nature, the characters of which are now sufficiently recognizable to enable us to form a correct diagnosis and to prevent us from pursuing an injurious mercurial (anti-syphilitic) treatment. Cod-liver oil and the general remedies used in scrofula are to be employed. Locally, tincture of iodine and perchloride of iron have not been very successful in Dr. C. Paul's hands, but he has found the acid nitrate of mercury to be of service.—*Lancet*, August 10, 1872.

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Diabetic Phthisis.—There is some difference of opinion in respect to the real character of phthisis in diabetic subjects, some considering it to be ordinary tubercular phthisis, whilst others deny it to be such. At a recent meeting of the Société de Biologie of Paris Dr. GRANCHET related an interesting case of cheesy pneumonia in a diabetic sufferer, in which the post-mortem showed that there did not exist real granulations, but that the interalveolar partitions contained a considerable number of embryonic elements. Dr. Granchet argued that, if it was not well-characterized tubercle, it was at least the tubercular process, and therefore he was opposed to Lancereaux and others, who do not admit the tubercular nature of phthisis in diabetes.—*Ibid.*

Pathological Anatomy of Diphtheritis.—In a paper recently read at the Academy of Sciences (*Gaz. Hebd.*, August 2), on the "Pathology of Gangrenous or Diphtheritic Angina and Croup," MM. Bouchut and Labadie-Lagrave came to the following conclusions: In these diseases there are two kinds of anatomical lesions—the one primary, due to the ulceration of the mucous membrane or the presence of false membranes; and the other secondary, cardiac or embolic. The former are well known, but the secondary, cardiac, and pulmonary embolic lesions have not yet been described,[1] and deserve to be known, explaining as they do the occurrence of death through an entirely special lesion of the lungs and other organs. In the heart there is almost always (fourteen times out of fifteen) an *endocardite végétante* with fibrinous deposits which are the origin of frequent emboli. The lungs frequently (forty-five times out of 180) contain knots of pulmonary apoplexy or bloody infarcti, due to arterial emboli, such infarcti being sometimes colourless at the centre, and surrounded by a zone of hyperæmic pulmonary tissue. Sometimes there are knots of purulent infiltration, or even true metastatic abscesses. The lungs also frequently present at their surface, between the lobules, small venous thrombi. These bloody infarcti are sometimes found under the pericardium among the altered muscular fibres of the heart, and in the subcutaneous cellular tissue, where small metastatic abscesses may be formed. Venous thrombi exist also in the pia mater, the brain, the liver, and in different parts of the body. With these lesions there always coexists a more or less pronounced leucocytosis, which in a bad case is very considerable.—*Med. Times and Gaz.*, August 17, 1872.

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The Structure of Normal and Varicose Veins.—Dr. S. Soboroff has lately undertaken a series of researches on the structure of healthy and varicose veins, the results of which possess considerable interest. He had at his disposal eight specimens of varicose veins, which, with only one exception, were accompanied by pathological changes in the vena saphena. These were all capable of being arranged in two groups: in both the lumen of the vessels was greatly enlarged; but in one the walls were thickened, in the other they were attenuated. The preparations seem to have been prepared with great care, some being silvered, to show the epithelium; others subjected to the action of chloride of gold, chloride of palladium, and chromic acid. The principal fact that he has definitely ascertained is that a dilated venous trunk, even when possessing almost perfectly transparent walls, contains colossal muscular fibre-cells. These are so large that when first observed they were regarded as fasciculi of unstriped muscle, but more careful examination, aided by staining experiments, showed the well-marked outline of the cells and the rod-shaped nuclei, clearly demonstrating that fibre-cells alone were under the microscope. The adventitia of the thin dilated veins was thin and but sparingly supplied with vessels, and the epithelial lining of these attenuated vessels was apparently continuous and unaltered. In the thickened and dilated veins, on the other hand, the adventitia was hypertrophied, and the vessels distributed to it were large and numerous.—*Lancet*, July 13, 1872.

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The International Ophthalmological Congress.—The first session of the Congress was held in London on August 1, 2, and 3. Fifty-eight gentlemen were present. Prof. Donders was elected President, and Dr. Williams, of Boston, and M. Warlomont, of Brussels, Vice-Presidents. Mr. Hulke, of London, and Prof. Zehender, of Berne, Hon. Secretaries.

Numerous papers of scientific interest were read. The Congress adjourned to meet in New York in September, 1876.

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Alsace-Lorraine Medical Students of the Free School of Medicine.—These students have issued an address to the public, protesting against the substitution of a German faculty for that whose doors have

[1] The authors are apparently unacquainted with the observations of Dr J. Forsyth Meigs, of Philadelphia. See *American Journal of Med. Sci.*, April, 1864, p. 305, and Jan. 1869, p. 24.

been closed. The introduction of a new scholastic programme, and of a new language is, they say, a serious blow not only to their patriotism, but to their interests, their studies, and their future. The address terminates with expressions of thanks and of veneration to their teachers who have to this period devoted their time and labour to preserve to Alsace its scientific self-government.—*L'Union Médicale*, August 10, 1872.

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Faculty of Medicine of Paris.—Dr. BROWN-SEQUARD, the eminent physiologist, has resigned the chair of Comparative and Experimental Physiology in this faculty which he has ably filled for several years. M. VULPIAN, a distinguished experimental physiologist, is an applicant for the vacant chair.

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OBITUARY RECORD. — Died in London, August 15, 1872, aged 72, FREDERIC C. SKEY, C.B., F.R.S., Consulting Surgeon to St. Bartholomew's Hospital, well known as an able and accomplished surgeon, a popular lecturer, and the author of many valuable surgical papers.

—— In London, August 21, 1872, ALFRED POLAND, Esq., Lecturer on Clinical Surgery at Guy's Hospital. Mr. Poland ably edited, some years since, in conjunction with Dr. Wilks, Guy's Hospital Reports, and he contributed many valuable papers to that work, and also to Holmes's System of Surgery. He was an expert and skilful operator, and highly esteemed for his honourable career.

—— In Paris, August 28, 1872, of disease of the genito-urinary organs, Dr. P. C. A. LOUIS, aged 86; well known by his celebrated work on typhoid fever, and other highly important contributions to medical science which have rendered his name illustrious. He was for many years Physician to the Hôtel Dieu, was a teacher of extraordinary ability, and justly regarded as one of the greatest authorities of his day, and that too at a time when Paris could boast of so many eminent physicians.

—— In Paris, August —, of disease of the heart, in the 59th year of his age, EUGENE NAPOLEON VIGLA, Physician to the Hôtel Dieu.

—— In Paris, July 5, 1872, of heart disease, M. CHARLES PIERRE DENONVILLIERS, aged 64. M. D. was appointed by *concours* Professor of Anatomy in 1846, in succession to Professor Breschet. In 1856 he succeeded Professor Gerdy to the chair of Surgical Pathology. In September, 1865, he was appointed to the Professorship of Operative Surgery, which became vacant by the death of the illustrious Malgaigne; and in 1867 he was promoted to the chair of Clinical Surgery at the Hôpital la Charité, which he held till the end of last year, when, having attained the age of 63, he had to retire, according to the rules recently established for hospital physicians and surgeons.

M. Denonvilliers, though a talented man and a practical surgeon, had not distinguished himself much as an author. He, however, contributed largely to the medical periodicals of the day, and wrote two very excellent works—one entitled "Compendium de Chirurgie," in conjunction with M. Gosselin; and the other "Rapports sur les Progrès de la Chirurgie," which appeared in 1867, and in which he was assisted by Nélaton, Velpeau, and others. He was for his services appointed in 1845 "Chevalier" of the Legion of Honour. In 1857 he was promoted to the rank of "Officier," and in August, 1865, to that of "Commandeur." He was, besides, Inspector-General of the medical branch of Public Instruction.

—— In Paris recently, Dr. M. BOUSQUET, one of the most eminent of the promoters of the Jennerian doctrines in France, aged 76, long since retired from practice with a good competence, which he has devoted to the erection of and providing for a hospital. In medical history he will be remembered as one of the most able and determined opponents of Broussais in the pages of the *Révue Médicale*, between 1820 and 1830, and therefore when the great antiphlogistic advocate was at the height of his popularity. Bousquet's "Traité sur la Vaccine" is one of the best works upon the subject, and has done immense service to the cause he had so much at heart, and which he defended to the last when it was threatened by the inroads of "animal vaccination."

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